

Michigan Department of Community Health
EMS AND TRAUMA SYSTEMS SECTION
P.O. Box 30717
Lansing, Michigan 48909
(517) 241-0179

*Authority: P.A. 368 of 1978, as amended
This form is for information only.*

RE-LICENSURE INSTRUCTIONS

INSTRUCTIONS FOR MFR, EMT, EMT-SPECIALIST AND PARAMEDIC

To qualify for re-licensure your previous Michigan EMS license must have expired within the last three years. All other applicants must use the initial Application for Licensure form.

1. Complete the re-licensure application form BHPPA/EMS-400 marking the box for the appropriate level you are applying to re-license. Submit it with the appropriate fee to the EMS & Trauma Systems Section with the check or money order made out to the State of Michigan. **Application fees are non-refundable.**
2. If you have a yes answer to question number 1 or 2 on page 2 of the application, be sure to enclose a criminal conviction form DCH-HLD-002 (7/04) or signed explanation including offense, dates, location and other pertinent information.
3. With your application submit the copies of certificates or other acceptable documentation of continuing education credits and a copy of your current CPR card. **Refer to EMS Personnel Continuing Education Form BHPPA/EMS-127 for category and lecture/practical requirements.** All continuing education credits must have been completed within three years of the date of the re-licensure application.
4. If you have been licensed in another state, since the expiration of your Michigan license, you are required to forward a *Verification of Out-of-State Licensure Form (BHPPA/EMS-251)* to the licensing agency in each state for their completion and submission directly to this office. National Registry is not a state; therefore, do not send this form to the National Registry.
5. Failure to complete the application in its entirety and correctly may result in a delay of the processing of your application. This is a two-page application. Be sure to complete both pages/sides, sign and date your application before submitting with the appropriate fee.

INSTRUCTOR/COORDINATOR RE-LICENSURE

1. Complete the re-licensure application form marking the box for Instructor Coordinator and submit it with the appropriate fee to the EMS & Trauma Systems Section with the check or money order made out to the State of Michigan. **Application fees are non-refundable.**
2. If you have a yes answer to question number 1 or 2 on page 2 of the application, be sure to enclose a criminal conviction form DCH-HLD-002 (7/04) or signed explanation including offense, dates, location and other pertinent information.
3. With your application submit copies of certificates or other acceptable documentation of Instructor Coordinator continuing education credits. Refer to Instructor Coordinator Continuing Education Record Form BHPPA/EMS-128. All CE's must have been completed within three years of the date of the re-licensure application.
4. Failure to complete the application in its entirety and correctly may result in a delay of the processing of your application. This is a two-page application. Be sure to complete both pages/sides, sign and date your application before submitting with the appropriate fee.

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**APPLICATION FOR RELICENSURE - LICENSE EXPIRED
 WITHIN LAST 3 YEARS**

Authority: Public Act 368 of 1978, as amended.
 If this form is not complete a license will not be issued.

Type or Print Only

I AM APPLYING FOR: (Check ONE only)

- ☐ **Medical First Responder - Fee: \$50.00 71-3204-06**
- ☐ **Emergency Medical Technician (Basic) – Fee: \$75.00 71-3203-06**
- ☐ **EMT-Specialist (NR-Intermediate 85) – Fee \$75.00 71-3202-06**
- ☐ **Paramedic – Fee: \$75.00 71-3201-06**
- ☐ **EMS Instructor/Coordinator Exam/License – Fee: \$75.00 71-3205-53**

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH. Fees are deposited upon receipt and are NON-REFUNDABLE.**

State Office Use Only

License Number

Date of Licensure

First Name	Middle Name	Last Name
U.S. Social Security Number		Date of Birth
Street Address		
City	State	ZIP Code
All Previous Names and/or Birth Name Used (If Applicable)		Daytime Phone Number

Check the appropriate answer to each of the following questions.

1. Have you been convicted of a misdemeanor or felony, other than minor traffic violations within the last three years? <input type="checkbox"/> Yes <input type="checkbox"/> No NOTE: Attach a detailed explanation or criminal conviction form DCH-HLD-002 (7/04) for a Yes answer		
2. Have you ever had a federal or state health professional license or registration revoked, suspended, or otherwise disciplined, been denied a license or currently have disciplinary action pending against you? <input type="checkbox"/> Yes <input type="checkbox"/> No NOTE: Attach a detailed explanation for a Yes answer		
3. Do you hold, or have you ever held an emergency medical services license in any state? List each state, the license number, and the date issued. You must have each state's licensing agency verify licensure directly to this office. (Attach additional sheets, if necessary) <input type="checkbox"/> Yes <input type="checkbox"/> No		
State	License/Registration Number	Date of Issue

Name	Social Security Number
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CERTIFICATION

I certify that I am the person named on this application and that all statements are true. Once licensed, I will comply with all applicable state laws and rules.

I understand that it is the policy of this agency to secure criminal conviction history as part of the pre-licensure screening process, and I authorize the agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record keeping organization.

I further consent to the release of information to this agency regarding any discipline investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state of the United States, military branch of the federal government or any sovereign nation.

The statements in this application are true and correct. I have not withheld information which might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation may be punishable by law.

Signature	Date
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VERIFICATION OF OUT-OF-STATE LICENSURE

Authority: Public Act 368 of 1978, as amended.

PART I – To be completed by the applicant and forwarded to the appropriate State Licensing Agency for completion.

Please indicate the level of licensure for which you are requesting verification:		
<input type="checkbox"/> Medical First Responder	<input type="checkbox"/> Emergency Medical Technician	<input type="checkbox"/> EMT-Specialist/Intermediate 85 <input type="checkbox"/> Paramedic
First Name	Middle Name	Last Name
All Previous Names and/or Birth Names Used (if applicable)	Date of Birth	Social Security Number
State Agency	License Number	Date of Issue

The applicant named above has applied for licensure in Michigan and has indicated licensure on your state. Please complete Part II of this form and return it to the address shown above.

PART II – To be completed by the State Licensing Agency

License Type	License Status <input type="checkbox"/> Current <input type="checkbox"/> Lapsed <input type="checkbox"/> Inactive	Expiration Date
Has the applicant incurred and disciplinary proceedings in your State? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, please attach certified copies of any actions.)		Are disciplinary proceedings pending? <input type="checkbox"/> No <input type="checkbox"/> Yes
Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended, or revoked? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, please attach certified copies of any actions.)		
If applying for MFR , Did the applicant's training include the following: <input type="checkbox"/> Spinal Immobilization		
If applying for EMT , Did the applicant's training include the following? <input type="checkbox"/> Double lumen airway		
If applying for EMT Specialist (Intermediate 85) , Did the applicant's training include the following (check the appropriate box(es))? <input type="checkbox"/> IV Therapy (fluid replacement only) <input type="checkbox"/> Endotracheal intubation <input type="checkbox"/> Double lumen airway		
If applying for Paramedic , Did the applicant's training include (check the appropriate box(es))? <input type="checkbox"/> IV Therapy <input type="checkbox"/> Medication administration <input type="checkbox"/> Endotracheal intubation <input type="checkbox"/> Manual defibrillation		
If this person is currently licensed as an EMT Specialist (Intermediate 85) or Paramedic, do they currently hold or have they held in the past, certification/licensure at the EMT level? <input type="checkbox"/> No <input type="checkbox"/> Yes		

CERTIFICATION

I hereby certify that, to the best of my knowledge, the information above is true to the records of this Board.

Signature _____

Date _____

Type or Print Name _____

Title _____

Name of Licensing Agency _____

(S E A L)

Phone Number _____

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs know to this agency